Blue Cross® of Idaho

An Independent Licensee of the Blue Cross and Blue Shield Association

State of Idaho
Medical Enrollment Application

If you have questions, call:
Department of Administration
Office of Group Insurance
650 W. State Street
Boise, ID 83720-0035
208-332-1860 or 1-800-531-0597
ogi@adm.state.id.us

POLICY TYPE (please check one):

❏ **PPO**

❏ **Traditional**

Date of Application: ____________________

Effective Date *(subject to BCI approval):* ____________________

Group Number: 10040000

Please complete *each* section on the front and back page of this application in ink.

Applicant Information (Employee)

Your Name *(first, initial, last)*	Blue Cross ID Number *(if currently enrolled)*	Social Security Number / /	Date of Birth / /	❏ Male ❏ Female
Mailing Address	City, State, Zip Code		Phone Number ( )	
Hire Date	Rehire Date	Marital Status: ❏ Single ❏ Married ❏ Divorced ❏ Widowed Common Law: ❏ Yes ❏ No Date of Marriage: ________	State **Department** or agency with which you are employed:	

COMPLETE ONLY TO DECLINE ALL BENEFITS *(Do not complete the information below this box.)*
I hereby decline **all** benefits and understand they may be added at a later date subject to waiting periods and other eligibility requirements as outlined in the State of Idaho member contract and employee handbook.

Signature: ____________________ **Date:** ____________________

Type of Enrollment

MEDICAL
- ❏ Self only
- ❏ Self and spouse
- ❏ Self, spouse and 1 child
- ❏ Self, spouse and 2+ children
- ❏ Self and 1 child
- ❏ Self and 2+ children

VISION*
- ❏ Self only
- ❏ Self and dependents

Change Request

- ❏ New Hire
- ❏ Marriage
- ❏ Death
- ❏ Involuntary loss of coverage
- ❏ Open Enrollment
- ❏ Divorce
- ❏ Add Dependent
- ❏ Court order (copy of court order required)
- ❏ Transfer
- ❏ Birth
- ❏ Delete Dependent
- ❏ Adoption

Date event occured: ____/____/____

Dental Enrollment (Dental benefits and eligibility not administered by Blue Cross of Idaho)*

❏ Self only ❏ Self and dependents

***If I decline vision and dental coverage for my dependents, I understand that they may not be added to coverage until the State of Idaho conducts a special open enrollment period.**

Spouse & Eligible Children to be Enrolled (list all family members you wish to enroll)

Family Member's Name *(first, initial, last)*	Social Security No.	Relationship to Applicant (spouse, child, stepchild, etc.)	Date of Birth (mm/dd/yy)	
	/ /		/ /	❏ Male ❏ Female
Family Member's Name *(first, initial, last)*	Social Security No. / /	Relationship to Applicant (spouse, child, stepchild, etc.)	Date of Birth (mm/dd/yy) / /	❏ Male ❏ Female
Family Member's Name *(first, initial, last)*	Social Security No. / /	Relationship to Applicant (spouse, child, stepchild, etc.)	Date of Birth (mm/dd/yy) / /	❏ Male ❏ Female
Family Member's Name *(first, initial, last)*	Social Security No. / /	Relationship to Applicant (spouse, child, stepchild, etc.)	Date of Birth (mm/dd/yy) / /	❏ Male ❏ Female
Family Member's Name *(first, initial, last)*	Social Security No. / /	Relationship to Applicant (spouse, child, stepchild, etc.)	Date of Birth (mm/dd/yy) / /	❏ Male ❏ Female

Is spouse a State of Idaho employee? **❏ YES ❏ NO If YES, spouse's name:** ____________________

Social Security Number: ____________________ **Department:** ____________________

SPOUSE MUST COMPLETE A SEPARATE APPLICATION TO ENROLL OR TO DECLINE COVERAGE.

Prior Coverage Information *(Please complete for proper crediting of waiting periods.)*

Has any person listed on this application been covered by any other health insurance, including Medicare, Medicaid, or other Blue Cross of Idaho policy, during the 12 months prior to the requested effective date of this application? ❏ Yes ❏ No If **YES**, please complete all information below for **each** person listed on this application.

Applicant's Name	Name of Carrier	Policy Number	Type of Policy (Group or Individual)	Date of Policy Start Date (mm/dd/yy)	End Date (mm/dd/yy)
Employee					
Spouse					
Child					
Child					
Child					

- If you have had other coverage with another carrier within 63 days of this request, please attach a copy of your **Certificate of Health Coverage** (HIPAA); this will ensure proper credit for any preexisting conditions, if applicable.
- If your coverage is terminated, please state reason: ____________________

OVER ⇨

Original applications must be submitted to your AGENCY HUMAN RESOURCES OFFICE

FOR OFFICE USE ONLY

Group Number	Subgroup	HIPAA Credit Days			Effective Date	Plan ID M	D	Y	Class	Reason Code
		Credit Days	Start	End		M	D	Y		
10040000										

White – Office of Group Insurance **Canary –** Office of Group Insurance **Pink –** Agency Human Resources Office

Form No. 3-700 (08-04)

Auditor ____________

Current Coverage Information *(Please complete for proper coordination of benefits administration.)*

Is any person listed on this application now covered by any other health insurance, including Medicare, Medicaid, or other Blue Cross of Idaho policy? ❑ Yes ❑ No If **YES**, please complete all information below for **each** person listed on this application.

Applicant's Name	Name of Carrier	Policy Number	Type of Policy (Group or Individual)	Start Date of Policy (mm/dd/yy)	Will Current Policy Continue?
Employee					❑ Yes ❑ No
Spouse					❑ Yes ❑ No
Child					❑ Yes ❑ No
Child					❑ Yes ❑ No
Child					❑ Yes ❑ No

If any person listed on this application is covered by Medicare, please complete the following:

Name _____ Medicare Beneficiary Number _____ Reason for Medicare Entitlement (age, disability of ESRD) _____

Date of Medicare Entitlement: Part A _____/_____/_____ (mm/dd/yy) Part B _____/_____/_____ (mm/dd/yy)

• If your current coverage will remain active, please indicate if coverage is for: ❑ Medical ❑ Dental ❑ Vision

Disability Information

Total disability is a condition resulting from disease or accidental injury, as certified in writing by an attending physician, that renders the enrollee/member incapable of performing the principal duties of regular employment/occupation for which he/she is qualified/trained and he/she is not engaged in any work, profession or avocation for fees, gain or profit; or he/she is unable to engage in the normal activities of an individual of the same age and gender.

Are you or any of your dependents currently *totally* disabled? ❑ YES ❑ NO *(If YES, complete information below.)*

_____
Nature of Total Disability

_____ _____ _____
Name of Totally Disabled Person *Physician's Name* *Physician's Phone Number*

_____ _____
Date of Total Disability *Physician's Address*

Statement of Understanding

By signing this application, I represent that all my answers are complete and accurate, and that I understand and agree to the following conditions:

- No independent producer, agent or employee of the insurer, or my employer can change any part of this application or waive the requirement that I answer all questions completely and accurately.
- The insurer may, at its discretion, request supplemental information from me, any family member listed on this application or any health care provider.
- On behalf of myself and all enrolled family members, I understand if the insurer discovers any intentional misrepresentation, omission or concealment of fact in obtaining coverage that was or would have been material to the insurer's acceptance of a risk, extension of coverage, provision of benefits or payment of any claim, the insurer may take action against my employer, including but not limited to increasing premiums.
- If this application is approved, coverage for myself and any eligible family members named on this application will begin on the date assigned by the insurer.
- I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law. For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Blue Cross of Idaho Notice of Privacy Practices that is available at ***www.bcidaho.com***.
- Preexisting condition waiting period: There are no benefits available under this policy for services, supplies, drugs or other charges that are provided within 12 months after an insured's enrollment date for any preexisting condition.

  A preexisting condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the six months immediately preceding the enrollment date. A pregnancy existing on the enrollment date is not a preexisting condition under this policy. Genetic information shall not be considered as a preexisting condition in the absence of a diagnosis of the condition related to such information.

In certain circumstances, qualifying previous coverage will be credited toward the preexisting condition waiting period.

- If you have had group or individual health coverage or a government health care program for at least 12 months, you are entitled to receive a Certificate of Creditable Coverage from your previous employer or insurance company. This document will state the effective date of prior coverage and the termination date of coverage for you and any covered dependents. Your previous employer or insurance company will furnish you this certificate upon request. If you need assistance in obtaining a certificate, your current employer or Blue Cross of Idaho can assist you.
- My employer's master group policy is the document that sets forth all terms of my coverage, and no independent producer, agent or other person can change the terms of the master group policy, any of its amendments, or this application, except with an amendment issued expressly for that purpose and signed by an authorized officer of the insurer.
- I understand that this application will become part of the contract between the insurer and my employer.
- **I affirm that I have reviewed all answers given on this application and, regardless of whether an independent producer or other person has filled out the answers for me, I verify that the answers are true and complete.**

APPLICATION MUST BE SIGNED AND DATED

Signature_____

Date_____